Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PARKWAY, SUITE G GRAND PRAIRIE, TX 75050	MFDR Tracking #: M4-11-0159-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: STANLEY WORKS Box #: 42	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Pre-authorization #00013BHC2951"

Amount in Dispute: $1,740.80

PART III: RESPONDENT'S POSITION SUMMARY

The respondent did not respond to this dispute.

Response Submitted by: N/A

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/18/09	97546-WH	$51.20 x 6 hours = $307.20	$307.20	$307.20
9/21/09	97545-WH	$51.20 x 2 hours = $102.40	$102.40	$102.40
9/21/09	97546-WH	$51.20 x 6 units = $307.20	$307.20	$307.20
9/23/09	97545-WH	$51.20 x 2 hours = $102.40	$102.40	$102.40
9/23/09	97546-WH	$51.20 x 6 units = $307.20	$307.20	$307.20
9/24/09	97546-WH	$51.20 x 6 units = $307.20	$307.20	$307.20
9/25/09	97546-WH	$51.20 x 6 units = $307.20	$307.20	$307.20
			Total Due:	$1,740.80

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Tex. Admin. Code §134.204 sets out the medical fee guidelines for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 10/23/2009 for dates of service 9/21/2009 and 9/23/2009

   - UMO1-198 – Payment denied/reduced for exceeded precertification/authorization. Adequate clinical justification does not appear to have been established. Number of agreed upon visits appear to have been exhausted.

Explanation of benefits dated 10/30/2009 for dates of service 9/18/2009, 9/24/2009 and 9/25/2009

- UMO1-198 – Payment denied/reduced for exceeded precertification/authorization. Adequate clinical justification does not appear to have been established. Number of agreed upon visits appear to have been exhausted.

Issues

1. Did the disputed services require preauthorization and did the requestor submit proof the services rendered were preauthorized?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT codes 97545-WH and 97546-WH on the above listed dates of service and the insurance carrier denied these services with above reason code "UMO1-198". Pursuant to rule §134.204(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. Division records support that the requestor, Integra Specialty Group is not CARF accredited and services do not qualify as an exempted Division Return to Work Rehabilitation Program. Pursuant to rule §134.600(p)(4) Non-emergency health care requiring preauthorization includes: all non-exempted work hardening programs. Therefore, preauthorization by the requestor is required for work hardening. The requestor submitted a copy of a pre-authorization approval supporting authorization of ten sessions of work hardening from 9/8/2009 through 9/30/2009. The disputed dates of service fall within this date range. Therefore, reimbursement to the requestor for the above listed dates of service is recommended. Under rule §134.204(h)(3)(A), The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." Under rule §134.204(h)(1)(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. The hourly reimbursement is $51.20 (MAR amount is $64.00 x 80% = $51.20).

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,740.80.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $1,740.80 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	6/20/11 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.